Other Audits

Melody S. Irvine, CPC, CPMA, CEMC, CPC-I, CCS-P, CMRS

Objectives

- Psychiatric and Psychotherapy Services
- Physical Therapy Services
- Laboratory/Pathology Services
- CMS/CPT documentation requirements

Psychiatric Verses Psychotherapy Services

- Psychologist/Psychiatrist are used interchangeably
- Psychiatric
  - Study of mental disorders and their diagnosis
- Psychotherapy
  - Study of people
    - Think, act, react, interact

Psychiatric Services

- The health and behavior assessment or intervention codes are used for psychologists assessing and counseling patients with medical illnesses.
- Known medical illnesses
- Not used for well patients

Psychiatric & Psychotherapy Documentation Requirements

- Documentation guidelines are for Psychiatric and Psychotherapy
- Record should be complete and legible
- Each visit should include:
  - Date, name, age, sex, date of birth
  - Chief Complaint
  - Appropriate history

Psychiatric & Psychotherapy Documentation Requirements

- Each visit should include: (con't)
  - Review of testing
    - Lab results, x-rays, other technical services
  - Assessment, clinical impression
    - Verbal and non-verbal communication
  - Mental Status
    - Ability to work psychotherapeutically

Psychiatric & Psychotherapy Documentation Requirements

- Each visit should include: (con't)
  - Plan of care
    - Goals, treatment plan, treatment duration
  - Diagnosis
    - Clinical and personality disorders, present medical condition, psychosocial and environmental problems
  - Examination

Psychiatric & Psychotherapy Documentation Requirements

- Each visit should include: (con't)
  - Health risk factors
    - Suicidal, homicidal, danger to themselves
  - Patient progress
    - Response or change in treatments, change in diagnosis or non-compliance

Psychiatric & Psychotherapy Documentation Requirements

- Each visit should include: (con't)
  - All entries should be dated and signed
  - Documentation should reflect ICD-9 and CPT codes billed

Psychiatric Diagnostic or Evaluative Interview

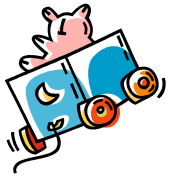
- 90801
- Includes: (guidelines we reviewed)
  - Chief complaint, history, review of testing, assessment, mental status, plan of care, diagnosis, examination, health risk factors, and patient progress
- An E/M service may be substituted for the initial interview

Psychiatric Diagnostic or Evaluative Interview

- 90801 (con't)
- Second provider may also use this code
- Some patients may require more than one visit to complete initial diagnostic evaluation
- Other informants may be seen in lieu of patient
- Diagnostic/therapeutic service may be initiated on same day
- Can only be billed three times per year

Interactive Psychiatric Interview

- 90802
- Includes same components as 90801
- Difference is interactive examination
  - Inanimate objects, toys, dolls, interpreter for deaf, language interpreter, other physical aids
- Can only bill three times per year



AAPC
Credentialing the Business Side of Medicine

Interactive Psychiatric Interview

- Additional elements required of 90802:
  - Referral source
  - Length of session
  - Content of session
  - Therapeutic techniques and approaches, including medications

Interactive Psychiatric Interview

- Additional elements required of 90802: (con't)
  - Patient's ability to adhere to treatment plan
  - Interactive therapy and rationale for technique
  - Multiaxial diagnosis

Alzheimer’s Disease

- Diagnosis of Alzheimer’s disease or related disorder check your Medicare contractor.
  - May be subject to payment
  - Alzheimer's is coded as 331.0 and is outside the code range of 290-319

Auditing Psychiatric Notes

- History and Medical Decision Making audit forms are the same for psychiatric as you would use with any other specialty audit
- See audit forms in handouts
  - History audit form
  - Medical Decision Making audit form
- What is different for psychiatric?
  - Examination

Auditing Examination

- Psychiatric Examination
  - See handout Psychiatric Examination Audit Form
  - 97 single organ examination
- Documentation Requirements:
  - Constitutional and psychiatric areas of the audit form are shaded
  - Psychiatrist must perform all the elements in those shaded boxes

Auditing Examination

- Bottom of the page defines the level of the exam
- Documentation Requirements:
  - Problem Focused – 1 to 5 elements
  - Expanded Problem Focused – At least 6
  - Detailed - At least 9
  - Comprehensive – Performed all elements in box with shaded border and at least one in unshaded border

Individual Psychotherapy

- 90804 – 90809 – Office or Outpatient
- 90816 – 90822 – Inpatient or Partial Hospital
- Attempts to alleviate the emotional disturbances, reverse or change maladaptive patterns of behavior, and/or encourage personality growth
- Based on time – face-to-face
- With medical evaluation and management services

Interactive Psychotherapy

- 90810 – 90815 - Office or Outpatient
- 90823 – 90829 - Inpatient or Partial Hospital
- Individual psychotherapy
- Interactive
  - Inanimate objects, toys, dolls, interpreter for deaf, language interpreter, other physical aids
- Based on time – face-to-face
- With medical evaluation and management services

Pharmacologic Management

- 90862
- Management of prescription medicine, observation, dosage regulation
- Do not report 90862 on same day as E/M service
- Primary reason is medication management use only 900862 and psychotherapy services
- M0064 used for lower level visit

Pharmacologic Management

- Documentation requirements:
  - Date and diagnosis
  - Current symptoms and problems
  - Problems, reactions and side effects
  - Description of optional minimal psychotherapeutic intervention, if any
  - Reasons for medication adjustments/changes or continuation

Sample Psychiatric Note

- You have a sample note for a Psychiatric Evaluation that you can review and answer the question.
- Remember to use the documentation guidelines to help answer the question
- Answer is at the bottom of the note

Physical Therapy Definitions

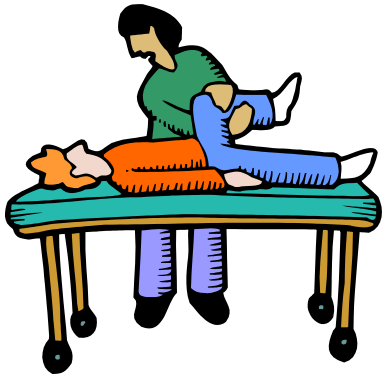
- Definitions
  - Active Participation
    - Clinician personally furnishes
  - Assessment
    - Clinical judgments regarding patient's condition
  - Certification
    - Approval of plan of care by physician
  - Episode of therapy
    - Period of time in calendar days

Physical Therapy Definitions

- Evaluation
  - Clinical judgments for patient conditions
- Re-evaluation
  - Unanticipated change in physical functional ability
- Interval
  - Number of days for treatment
- Treatment Day
  - Single calendar of treatment

Physical Therapy Documentation Requirements

- Evaluation
  - Patient performance/abilities
  - Diagnosis
  - Body part evaluated and includes conditions/complexities
  - Clinical judgments or impressions
  - Treatment determinations



Physical Therapy Documentation Requirements

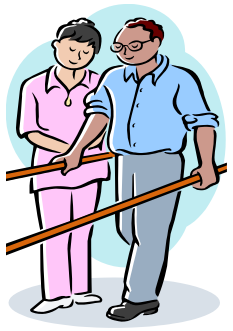
- Plan of care or plan of treatment
  - Diagnoses
  - Long term treatment goals
  - Type, amount, duration and frequency of therapy services
- Past Medical History
  - Function status prior to onset
  - The onset
  - Prior PT treatments

Physical Therapy Documentation Requirements

- Treatment Notes
  - Recording treatments provided and time
  - Identification of each specific intervention/modality provided and billed
  - Record each service represented by a timed code
    - Report in minute increments – do not include rest periods
  - Signature of qualified professional or supervised services

Physical Therapy Documentation Requirements

- Dictation
  - Complete on day it was dictated
- Discharge Note
  - Required for each episode of treatment



Physical Therapy Documentation Guidelines

- Progress reports
  - Justifies medical necessity of treatment
  - Written by clinician
  - Assessment of improvement
  - Plans for continuing treatment
  - Changes in long or short term goals

Change of Treatment Plan

- Therapist may not significantly alter plan without approval
- Difference between significant and insignificant change in plan
- Procedures/modalities do not require physician approval

Physical Therapy Assistants

- PTA's can write elements of Progress Report but are not complete reports
- Progress Reports by assistants should include:
  - Beginning and end dates of reporting period
  - Date report was written
  - Signature/identification who wrote the report
  - Patient statements
  - Measurement or description of changes

Auditing Physical Therapy

- When auditing physical therapy it is important to make sure all the documentation guidelines we just reviewed are met.

- Time is extremely important documentation for physical therapy

Sample Physical Therapy Note

- You have a sample note for Physical Therapy that you can review and answer the questions.
- Remember to use the guidelines to help with the answer to the questions
- Answers are on the bottom of the sheet

Laboratory/Pathology

- Definitions
  - Qualitative
    - Is it present
  - Quantitative
    - How much is present

Coding Guidelines
Pathology/Laboratory

- Documentation is required to support the medical necessity of laboratory testing
- If the ordering physician submits an ICD-9 code, the laboratory must use that code

Coding Guidelines
Pathology/Laboratory

- Screening tests are performed when no specific sign, symptom, or diagnosis is present and the patient has not been exposed to a disease.
- Contact with or exposure to communicable diseases should be assigned, not a screening code

Panels

- 80047 – 80076
- Cannot bill panels that overlap
- Report only the panel that is greater in the number of tests
- Example:
  - 80047 & 80053

Drug Testing

- 80100 – 80103
- 80100
  - Indentify present of a drug
  - 80100 can be used multiple times
- 80102
  - Confirmation of presence
- 82000 – 84999 test is quantitative

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Therapeutic Drug Assay

- 80150 – 80299
- Tests for adjustment of drug doses
- Peak
  - Drawing blood after drug is administered
- Trough
  - Drawing blood before next dose

Evocative/Suppression Testing

- 80400 – 80440
- Function and response of agent administered
- Physician administration of test charged separately
  - Infusion or therapeutic code, supplies, & E/M

Consultations

- 80500 – 80502
- Response or request from attending physician
- Must have interpretive judgment

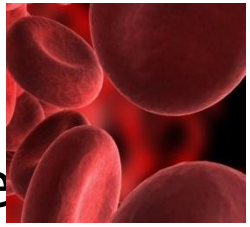
Urinalysis

- 81000 – 81099
  - Urinalysis by dipstick
  - Automated, non-automated, with/without microscopy, qualitative or semi-quantitative
  - Microscopic analysis is done to look at sediment in the urine
  - Urine culture tests detect and identifies bacteria and yeast

Chemistry

- 82000 – 84999
- A chemistry screen tells your doctor about your general health, helps look for certain problems
- Common tests in this area:
  - Blood occult, calcium, creatine, glucose, lipase, PSA, triglycerides, TSH, and uric acid

Hematology and Coagulation



- 85002 – 85999
- Blood counts are used to evaluate and diagnose diseases relating to abnormalities of the blood or bone marrow
- Hematology – study of blood and blood-producing organs
- Coagulation is the process of blood forming solid clots

Immunology

- 86000 – 86804
- Some of these tests are useful in the diagnosis of patients with immunological disorders.
- Some of the tests in this section
  - C-reactive protein, HIV testing, T Cells, Tuberculosis testing

Transfusion Medicine

- 86850 - 86999
- Blood transfusion is the transfer of blood or blood products from one person into another person's bloodstream.
- Testing is done to determine the ABO and RhD blood group.

Microbiology

- 87001 - 87999
- These tests study microorganisms and their effects on humans
- This includes
  - Bacteriology
  - Mycology
  - Parasitology
  - Virology

Cytopathology

- 88104 - 88199
- Pap Smears – detection of various conditions of the female genital tract.
- A pap smear can reveal the following dysplastic changes:
  - CIN I – 622.11
  - CIN II – 622.12
  - CIN III – 233.31
- Other ICD- 9 codes – 795.00 – 795.19

Cytogenetic Studies

- 88230 - 88299
- Cytogenetic studies describe the microscopic examination of the physical appearance of human chromosomes.
- These include:
  - Genetic disorders in a fetus
  - Failure of sexual development
  - Chronic leukemia
  - Acute leukemia lymphoid

Genetic Testing Modifiers

- Genetic testing modifiers will be used with cytogenetic studies, they can be found in Appendix I of CPT and are used in conjunction with CPT and HCPCS codes
  - First digit
    - Disease type
  - Second digit
    - Disease/gene

Surgical Pathology

- 88300 - 88399
- 88300 – 88309 - Require individual examination and/or diagnosis
- 88300 – 88309
  - Do not include codes 88311 – 88365, 88399
- More than one sample from the same patient is assigned individual codes

Surgical Pathology

- 88300 – Level 1 – gross examination only
  - Example: Teeth
- 88302 – Level II
- 88304 – Level III
- 88305 – Level IV
- 88307 – Level V
- 88309 – Level VI

Reproductive Medicine Procedures

- 89250 - 89356
- Initial screening evaluation of the male includes a history and two semen analysis.
- Semen cultures check for bacteria
- Some other codes include:
  - Micro-fertilization
  - Insemination to achieve fertilization
  - Identification, isolation and incubation of cells

CLIA

- Clinical Laboratory Improvement Amendments (CLIA)
- All laboratory testing sites must be registered with CLIA.
- The provider must have a certificate of waiver to perform these tests in office.
- Modifier QW usually needs to be appended to the HCPCS Level I or II code for Medicare claims

Advanced Beneficiary Notice

- ABN – waiver must be signed by Medicare patients BEFORE a lab test is performed

- ABN's can not be signed by all Medicare patients routinely.

Local Coverage Determinations
National Coverage Determinations

- NCD – National Coverage Determinations
- LCD – Local Coverage Determinations
- Three lists
  - Covered codes, non-covered codes and codes that do not support medical necessity
- Important piece for lab testing

ICD-9 Codes

- If the ICD-9 is not documented in the patient chart or an unsupported ICD-9 code is used to get the test paid, this would constitute fraud.
- Signed ABN's must be kept on file and a GA modifier is attached to the CPT lab code for submission to Medicare.

Summary

- To properly audit Psychiatry, Psychotherapy and Physical Therapy services, follow the documentation guidelines that have been outlined in this presentation.
- Lab codes
  - Understand the purpose of the lab codes
  - ICD-9 codes must support the medical necessity
  - Always check your local Medicare carrier for LCD coverage

Thank You

Questions?

HPI - HISTORY OF PRESENT ILLNESS

☐ Location ☐ Severity ☐ Timing ☐ Modifying Factors ☐ Quality ☐ Duration ☐ Context ☐ Associated Signs & Symptoms	**1-3 Brief**	**1-3 Brief**	**Extended** **> 4 elements or (95)** **> 3 chronic/inactive (97)**

ROS - REVIEW OF SYSTEMS

☐ Constitutional ☐ ENT ☐ Eyes ☐ Cardiovascular ☐ GI ☐ GU ☐ Respiratory ☐ Neurology ☐ Musculoskeletal ☐ Psychiatric ☐ Integumentary ☐ Endocrine ☐ Hem/Lymph ☐ Allergy/Immunology ☐ All other systems reviewed and are negative	**None**	**Pertinent to 1 system**	**Extended 2-9 systems**	**Complete 10 systems or all neg**

PFSH - PAST, FAMILY, SOCIAL HISTORY

EST PT.	☐ Past Medical History ☐ Family History ☐ Social History	**None**	**None**	**1 History**	**2- 3 History**
NEW PT	☐ Past Medical History ☐ Family History ☐ Social History	**None**	**None**	**1-2 History**	**3 History**
Level of history is determined by the column that is marked farthest to the left		**Problem Focused**	**Exp Prob Focused**	**Detailed**	**Comp**

HPI

Location - *Where on the body the symptom is occurring or problem experienced* _____

Quality - *Character of the symptom – burning, gnawing, stabbing, fullness, throbbing, sharp, dull, crushing, cramping, piercing, popping, metallic taste, how it looks or feels* _____

Severity – *Ranking of the symptom – Severe, slightly worse, chronic, can't describe, moderate distress, takes breath away, size of lump or mass, scale 1-10, improved, high blood sugars, so bad the patient can't sleep* _____

Duration – *How long the symptom has been present, when first symptoms occurred, time of onset of signs & symptoms, e.g., began in childhood, since 1995.* _____

Timing - *When the symptom happens – night, after meals, after medications; frequency - lasts 5 minutes, comes and goes, intermittent, constant, occasional, on and off, mornings*_____

Context – *Situation associated with the symptom – dairy products, big meals, on exertion, how the injury occurred, what they were doing when it happened or symptoms occurred, e.g., while sleeping, MVA, slipped and fell, eating certain foods* _____

Modifying Factors - *Things that are done to make the symptom worse or better, has anyone besides the patient attempted to relieve the problem or symptom, e.g., hurts when I move, no relief with medical care or medications, calms down when mother feeds, worse standing* _____

Associated Signs and Symptoms – *Other things that are happening – runny nose, sore throat, is also experiencing, along with, in addition to, etc. Secondary complaints*_____

ROS (should be medically necessary)

CONSTITUTIONAL – *Weight changes, fever, weakness, fatigue, general appearance, exercise tolerance, impairs ability*

EYES – *Glasses, contacts, last eye exam, glaucoma, cataracts, eyestrain, redness, diplopia, etc.*

EAR, NOSE, MOUTH, THROAT – *EARS – hearing, discharge, tinnitus, dizziness, pain; NOSE – Head cold, epistaxis, discharges, obstruction, post nasal drip, sinus pain; MOUTH/THROAT – Teeth/gums, last dental exam, soreness, redness, hoarseness, difficulty in swallowing*

CARDIOVASCULAR – *Chest pain, rheumatic fever, tachycardia, palpitations, high BP, varicose veins, thrombophlebitis, faintness, vertigo, color changes in fingers or toes, edema, leg pain when walking*

RESPIRATORY – *Chest pain, wheezing, cough, dyspnea, sputum (color/quantity), hempotysis, asthma, bronchitis, emplysema, pneumonia, tuberculosis, pleurisy, last chest x-ray*

GASTROINTESTINAL - *Appetite, thirst, nausea, vomiting, hematemesis, rectal bleeding, change in bowel habits, diarrhea, constipation, indigestion, food intolerance, flatus, hemorrhoids, jaundice, heartburn, abdominal swelling, digestive aids or laxatives*

GENITOURINARY – *Urinary: frequent or painful urination, nocturia, pyuria, hematuria, incontinence, urinary infection. Gastroreproductive:* ***male*** *- venereal diseases, sores, discharge from penis, hernias, testicular pain or masses* ***female*** **-** *age of menarche and menstruation (frequency, type, duration, dysmenorrheal, menorrhagia, symptoms of menopause), contraception, pregnancy, deliveries, abortions, last pap*

MUSCULOSKELETAL – *Joint pain or stiffness, arthritis, gout, backache, muscle pain, cramps, swelling, redness, limitation in motor activity*

INTEGUMENTARY (SKIN/BREAST) – *Rashes, eruptions, dryness, cyanosis, jaundice, changes in skin, hair/nails, hot, cold, lesions, scars, moles, bruising, breast pain, tenderness, swelling, lumps, nipple discharge*

NEUROLOGICAL – *Faintness, blackouts, seizures, paralysis, tingling, tremors, memory loss, convulsions, attention difficulties, hallucinations, disorientations, speech & language dysfunction, balance, coordination*

PSYCHIATRIC – *Personality type, nervousness, mood, insomnia headache, nightmares, depression, suicidal, sadness, anxiety, energy loss, restlessness, irritability, mood swings*

ENDOCRINE – *Thyroid trouble, heat or cold intolerance, excessive sweating, BS readings, increased appetite/thirst or urination, changes in height/weight*

HEMATOLOGIC/LYMPHATIC – *Anemia, easy bruising or bleeding, past transfusions, swollen glands, night sweats, itching with no rash*

ALLERGIC/IMMUNOLOGIC - *Allergies to medicine, food, dye, hepatitis, HIV*

Psychiatric Examination

System/Body Area	Elements of Examination
Constitutional	• Measurement of **any three of the following seven** vital signs: 1) sitting or standing blood pressure, 2) supine blood pressure, 3) pulse rate and regularity, 4) respiration, 5) temperature, 6) height, 7) weight (May be measured and recorded by ancillary staff) • General appearance of patient (eg, development, nutrition, body habitus, deformities, attention to grooming)
Head and Face	
Eyes	
Ears, Nose, Mouth and Throat	
Neck	
Respiratory	
Cardiovascular	
Chest (Breasts)	
Gastrointestinal (Abdomen)	
Genitourinary	
Lymphatic	
Musculoskeletal	• Assessment of muscle strength and tone (eg, flaccid, cog wheel, spastic) with notation of any atrophy and abnormal movements • Examination of gait and station
Extremities	
Skin	
Neurological	

System/Body Area	Elements of Examination
Psychiatric	• Description of speech including: rate; volume; articulation; coherence; and spontaneity with notation of abnormalities (eg, perseveration, paucity of language) • Description of thought processes including: rate of thoughts; content of thoughts (eg, logical vs. illogical, tangential); abstract reasoning; and computation • Description of associations (eg, loose, tangential, circumstantial, intact) • Description of abnormal or psychotic thoughts including: hallucinations; delusions; preoccupation with violence; homicidal or suicidal ideation; and obsessions • Description of the patient's judgment (eg, concerning everyday activities and social situations) and insight (eg, concerning psychiatric condition) Complete mental status examination including • Orientation to time, place and person • Recent and remote memory • Attention span and concentration • Language (eg, naming objects, repeating phrases) • Fund of knowledge (eg, awareness of current events, past history, vocabulary) • Mood and affect (eg, depression, anxiety, agitation, hypomania, lability)

Content and Documentation Requirements

Level of Exam	Perform and Document:
Problem Focused	**One to five** elements identified by a bullet.
Expanded Problem Focused	**At least six** elements identified by a bullet.
Detailed	**At least nine** elements identified by a bullet.
Comprehensive	Perform **all** elements identified by a bullet; document every element in each box with a shaded border and at least one element in each box with an unshaded border.

ABC Physical Therapy

Date: 10/7/XX

Patient Name: Michael Stone **Date of Birth**: 07/01/XX
Referring Physician: Peter Smith, MD
Treating Physical Therapist: Paul Temple, MPT
Insurance: XYZ Healthcare Plan
Insurance approved obtained: x **Yes** **No**
Date of Accident/Injury: 10/5/XX
Initial visit date: 10/7/XX
Diagnosis: RT – 719.41

Subjective

Chief Complaint

Right shoulder pain
Decreased ROM

Current Medications

800 mg ibuprofen daily

Symptoms

Severe pain in right shoulder radiating to right upper back occurring 3 – 5 times per hour and lasting 1-3 minutes since car accident
Moderate decreased range of motion in right shoulder since car accident

Activities of Daily Living

Activity: Lifting 50 lbs required for work
Aggravation: Pain increases from mild to moderate after 10 lbs
Limitation: Client has to stop the activity after 20 lbs because of pain

Past History

Patient declines any past history of shoulder pain or injuries

Objective

Tests and Measures

Gait, locomotion and balance:

Functional use of arm during gait

Muscle performance (strength, power, endurance):

No significant deficits in resisted movements

Posture:

Forward head position
Rounded shoulders
Flattening of thoracic spine

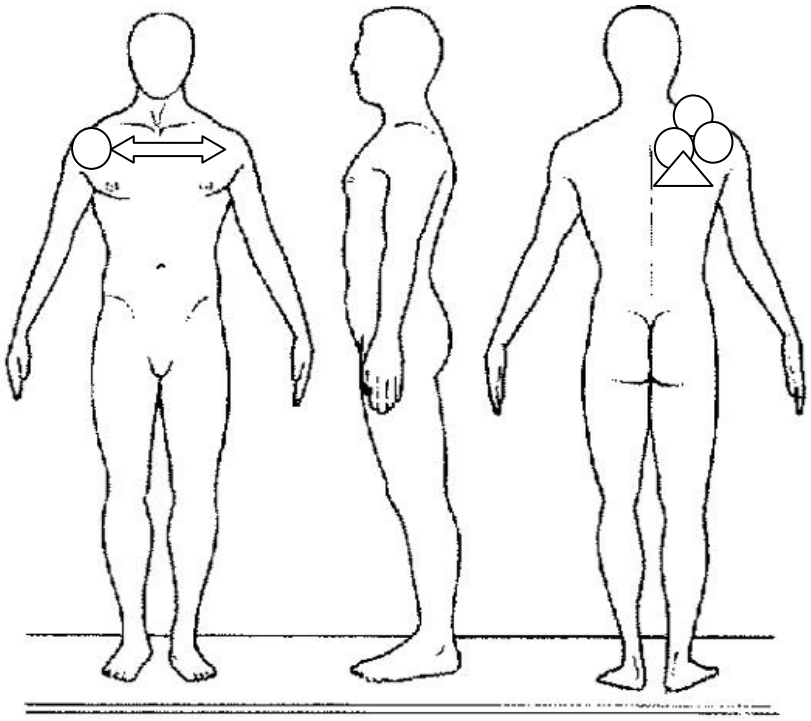
Range of motion:

Shoulder complex-right-active 10/7/xx

Movement	Position	Measure	Pain	Quality
Flexion	Supine	150°	None	Smooth
Extension	Prone	50°	None	Smooth
Abduction	Supine	140°	Moderate	Smooth
Medial Rotation	Supine	90°	None	Smooth
Lateral Rotation	Supine	45°	Moderate	Segmented

Legend

◯ Pain △ Adhesion ⟺ Short



Other:

- **Community and Work Reintegration:**
  - Delivery truck driver. Needs to be able to lift and carry 50 lb packages

Palpation

Muscle	Symptom	Location	Severity
Upper trunk, back, spinae group	Inflammation	Right	

Modalities

- **Application of cold:**
  - (5 minutes) Upper back, shoulders
- **Evaluation:**
  - 30 minutes
  -

- **Manual Therapy techniques:**
  - (15 minutes) Right shoulder, manually resisted exercises; right shoulder quadrant mobilization; scapula mobilization, myofascial release
- **Therapeutic Exercises** (15 minutes)
  - Right shoulder, PROM using pulley
  - Postural correction exercises

Assessment

- **Assessment**:
  - Impaired joint mobility, motor function, muscular performance and range of motion associated with capsular restriction of the right shoulder, right shoulder adhesive capsulitis.
- **Long Term Goals**:
  - Client will be able to lift and carry up to 50 lbs up to 1000 feet with a 1 minute break every 500 feet 10 times a day Monday to Friday with no more than mild fatigue within 60 days
- **Short Term Goals**:
  - Client will be able to lift and carry up to 25 lbs up to 200 feet with a 1 minutes break every 100 feet 3 times a day Monday to Friday with no more than moderate pain within 14 days.

Plan

- **Treatment Plan**:
  - Manual therapy techniques and therapeutic exercises, right shoulder, three times a week for 4 weeks, 30 minute sessions, to increase mobility and strength to WNL as compared to left side to perform work duties
- **Homework and Selfcare**:
  - Initiate stretching of right shoulder for 10 minutes once a day. Gave stretching handout.

What are the correct codes for today's services

A. 97001, 97010, 97110, 97140
B. 97002, 97110
C. 97003, 97010, 97110
D. 97005, 97010, 97140

Choose the correct answer below

A. This record is correctly documented
B. Documentation missing signature of therapist
C. Documentation missing time of modalities
D. Documentation missing long term goals

Answers

A 97001, 97010, 97110, 97140
B 97002, 97110
C 97003, 97010, 97110
D 97005, 97010, 97140

Rationale:
97001 for the evaluation, 97010 for application of the modality (cold packs), 97110 therapeutic procedure (for range of motion), 97140 for manual therapy.

A This record is correctly documented
B Documentation missing signature of therapist
C Documentation missing time of modalities
D Documentation missing long term goals

MEDICAL DECISION MAKING

DIAGNOSIS

Self-limited or minor (stable, improved, or worsening)	**(MAX 2)**	1	**X**	
Est. problem; stable, improved		1/dx	**X**	
Est. problem; worsening		2/dx	**X**	
New problem; no additional workup planned	**(MAX 1)**	3	**X**	
New problem; additional workup planned i.e., referred, testing		4	**X**	
		Total		

COMPLEXITY OF DATA REVIEWED OR ORDERED

Review and/or order clinical lab tests (80000)	1	
Review and/or order tests in radiology section (70000)	1	
Review and/or order tests in medicine section (90000)	1	
Decision to obtain old records and/or obtaining history from someone other than patient	1	
Review and summarization of old records and/or obtaining history from someone other than patient and/or discussion of case with another health provider	2	
Independent visualization of image, tracing or specimen itself (not simple review of report)	2	
Total		

RISK OF COMPLICATIONS AND/OR MOTALITY

	Presenting Problems	Diagnostic Procedure	Management Options
Min	One self-limited, minor problem e.g. cold, insect bite, Tinea Corporis	Lab Test requiring Venipuncture Chest x-ray or US, EKG/EEG, KOH prep or UA	Rest, Gargles, Elastic Bandage, Dressing
Low	2 or more self-limited or minor problems, 1 stable chronic illness, Acute illness or injury uncomplicated	Physiologic test not under stress e.g PFT Non cardiovascular image study with contrast, Superficial needle biopsy, Clinical lab requiring arterial puncture, Skin biopsies	OTC drugs, PT or OT, IV Fluids w/o additive Minor surgery no identified risk factors
Mod	One or more chronic illness with mild exacerbation or side effects of treatment, 2 or more chronic illness, Acute illness with uncertain prognosis, Acute complicated injury	Physiologic test not under stress, Diagnostic endoscopy with no identified risk factors, Deep needle or incision biopsy, Cardio/Vascular imaging study with contrast no identified risk factors, Obtain fluid from body cavity	Minor surgery with identified risk factors, Elective major surgery with no identifiable risk factors, Prescription drug management, Therapeutic Nuclear Medicine, IV's with additives, Closed treatment of fracture or dislocation w/o manipulation
High	1 or more chronic illness with severe exacerbation, progression or side effects of treatment, Acute or chronic illnesses or injury that may pose a threat to life or body function, Abrupt change in neurological status	Cardiovascular imaging studies with contrast with identified risk factors, Cardiac electrophysiological tests Diagnostic endoscopy with identified risk factors, Discography	Elective major surgery with identifiable risk factors, Emergency major surgery, IV controlled substances, Drug therapy requiring intensive monitoring for toxicity, Decision not to resuscitate or de-escalate because of poor prognosis

LEVEL OF MEDICAL DECISION MAKING

Level determined with 2-3 or center level

Diagnosis	1 or less	2	3	4 or more
Complexity	1 or less	2	3	4 or more
Risk	Minimal	Low	Moderate	High
LEVEL	**Straight Forward**	**Low**	**Moderate**	**High**